XVII Rural Health Clinic Services

Reimbursement will be made in accordance with 42 CFR 447.371, with payment for all services offered by the clinic at a single cost-reimbursement rate per clinic visit, established by the Medicare carrier, that includes the cost of all services furnished by the clinic, except for specified immunizations.

For services provided on or after October 1, 1988, rural health clinics will be allowed to secure drugs for specified immunizations from the Department for Health Services free to provide immunizations for Medicaid recipients. Upon receipt of notice from the rural health clinics that the drugs were used to provide immunizations to Medicaid recipients, the Department for Health Services will be reimbursed by the Department for Medicaid Services for the cost of the drugs.

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XVIII. Outpatient Surgical Clinics

Reimbursement will be made to freestanding outpatient surgical clinics on the basis of sixty-five (65) percent of their usual and customary charge for the procedure performed. Payment rates shall not exceed the provider's usual and customary charge to the general public. Hospital based outpatient surgical clinics shall be reimbursed in the same manner as hospital outpatient services.

XIX Nurse-Midwife Services

Participating nurse-midwife providers shall be paid only for covered services rendered to eligible recipients, and services provided shall be within the scope of practice of the nurse-midwife.

For services provided on or after July 1, 1990, payments to nurse-midwives shall be at usual and customary actual billed charges on a procedure-by-procedure basis, with reimbursement for each procedure to be the lesser of the actual billed charge or at seventy-five (75) percent of the fixed upper limit per procedure for physicians.

XX Nurse anesthetist services

Reimbursement will be made at the rate of seventy-five (75) percent of the anesthesiologist's allowable charge for the same procedure under the same conditions, or at actual billed charges if less.

Exception:

For inpatient delivery-related anesthesia services provided on or after December 1, 1988, a nurse anesthetist will be reimbursed the lesser of the actual billed charge or the standard fixed fee paid by type of procedure. Those procedures and fixed fees are:

Normal Delivery, $150.00;
Low Cervical C-Section, $202.50;
Classic C-Section, $240.00;
Epidural Single, $236.25;
Epidural Continuous, $251.25;
C-Section with Hysterectomy, subtotal, $240.00;
C-Section with Hysterectomy, total, $240.00;
Extraperitoneal C-Section, $240.00

XXI. Podiatry Services

The cabinet shall reimburse licensed, participating podiatrists for covered podiatry services rendered to eligible Medical Assistance recipients at the usual and customary actual billed charge up to the fixed upper limit per procedure established by the cabinet at 65 percent of the median billed charge for outpatient services and 50 percent of the median billed charge for inpatient services using 1989 calendar year billed charges. If there is no median available for a procedure, or the cabinet determines that available data relating to the median for a procedure is unreliable, the cabinet shall set a reasonable fixed upper limit for the procedure consistent with the general array of upper limits for the type of service. Fixed upper limits not determined in accordance with the principle shown in this section (if any) due to consideration of other factors (such as recipient access) shall be specified herein.

XXII Hospice Services

Reimbursement for licensed, participating hospices shall be at the rates provided for in Section 9505(c) of Public Law 99-272 (COBRA). In addition, for hospice patients in nursing facility beds participating in the Medicaid Program, the hospice shall be paid an amount for room and board furnished by the facility which is equal to ninety-five (95) percent of the Medicaid rate for the facility.

XXIII. Case Management Services

Case management providers who are public non-profit will be paid at an interim rate, approximating actual cost, which will be settled back to cost at the end of the state's fiscal year. Providers shall be required to provide acceptable documentation of costs. The detailed description of the cost-finding methodology is on file at the State Agency. Reimbursement to private providers will be the lesser of the billed charge or a fee-for-service which is based on usual and customary charges.

Targeted case management services for severely emotionally disturbed children and adults with chronic mental illness.

Payments shall be based on cost. An interim rate based on projected cost may be used as necessary with a settlement to cost at the end of the fiscal year.

Targeted case management services for children with developmental disabilities provided through an agreement with the Title V agency.

Payments for case management services are on a per encounter or per item basis. Payments shall be based on documented costs for the direct provision of services. Documented costs do not include payment for administrative and indirect overhead costs of the Title V agency or its contractor state agency, the Department for Mental Health and Mental Retardation Services. The Title V agency, (or its contractor state agency, the Department for Mental Health and Mental Retardation Services) must maintain, in auditable form, all records of expenditures for services for which claims of reimbursement are made to the Medicaid agency. Payments to state agencies shall not exceed actual documented costs. An interim rate based on projected cost may be used as necessary with a settlement to cost at the end of the fiscal year.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE Kentucky

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Item ~~XXIII~~ XXIV. Payment of Title XVIII Part A and Part B Deductible/Coinsurance

Except for a nominal recipient co-payment, if applicable, the Medicaid agency uses the following method:

	Medicare-Medicaid Individual		Medicare-Medicaid/QMB Individual		Medicare-QMB Individual	
Part A Deductible	___	limited to State plan rates*	___	limited to State plan rates*	___	limited to State plan rates*
	X	full amount	X	full amount	X	full amount
Part A Coinsurance	___	limited to State plan rates*	___	limited to State plan rates*	___	limited to State plan rates*
	X	full amount	X	full amount	X	full amount
Part B Deductible	___	limited to State plan rates*	___	limited to State plan rates*	___	limited to State plan rates*
	X	full amount	X	full amount	X	full amount
Part B Coinsurance	___	limited to State plan rates*	___	limited to State plan rates*	___	limited to State plan rates*
	X	full amount	X	full amount	X	full amount

*For those title XVIII services not otherwise covered by the title XIX State plan, the Medicaid agency has established reimbursement methodologies that are described in Attachment 4.19-B, Item(s) ___.

XXV. Advanced Registered Nurse Practitioner Services

Participating licensed advanced registered nurse practitioners (ARNP) shall be paid only for covered services rendered to eligible recipients, and services provided shall be within the scope of practice of a licensed advanced registered nurse practitioner.

For services provided on or after October 1, 1990, payment to licensed advanced registered nurse practitioners shall be at usual and customary actual billed charges on a procedure-by-procedure basis, with reimbursement for each procedure to be the lesser of the usual and customary actual billed charge or at 75 percent of the fixed upper limit per procedure for physicians.

An ARNP employed by a primary care center, federal qualified health center, or comprehensive care center shall not bill directly for services provided in connection with the center.

(Revised)

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Attachment 4.19-B
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XXVI: Federally Qualified Health Center Services

Enrolled Federally Qualified Health Center providers shall be paid full reasonable cost determined in the same manner as for primary care centers except that cost shall not include an incentive payment.